

**COUNTY PRENATAL BLOCK GRANT  
ANNUAL EVALUATION**

**2004-2005**

**Arizona Department of Health Services  
Office of Women's and Children's Health**

**Submitted by  
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## I. EXECUTIVE SUMMARY

In 1996 the Arizona Legislature authorized \$1,281,100 for the County Prenatal Block Grant (CPBG) to address the health care needs of women and infants in Arizona. According to the 1996 needs assessment report, conducted by the Office of Women's and Children's Health (ADHS 1996), there was a greater need to address such issues as: 1) no or late prenatal care by large numbers of pregnant women; 2) low birthweight which requires early risk assessment even prior to pregnancy; 3) attention to social and medical risk factors; and 4) promotion of healthy environments and quality preventive and medical care for infants. As this is a state-funded program, it has been subjected to two budgetary reductions. Since the original formula was developed in 1997, the counties' main target population, women of childbearing age, has increased by 24% throughout the state. However, annual funding has decreased by 10%. The following graph is a pictorial demonstration of one of the major barriers all counties have experienced (Figure 1). It is through excellent planning and creative financial strategies that counties have been able to continue to provide services.

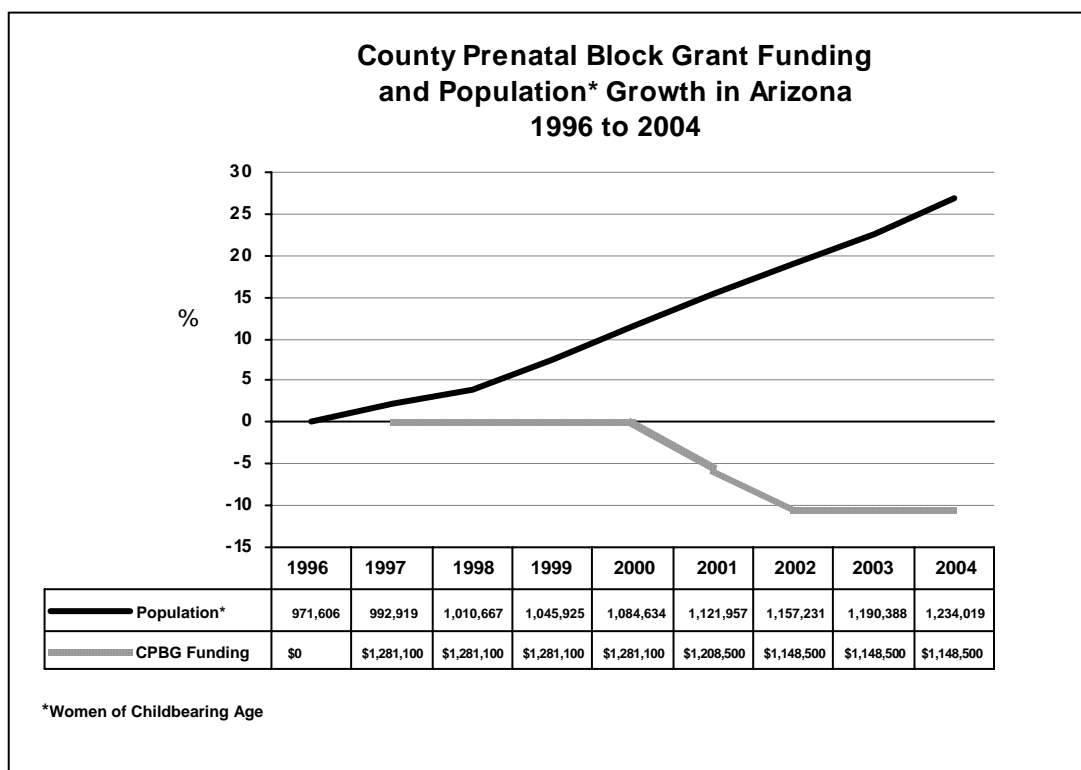


Figure 1 Source: Arizona Health Status and Vital Statistics, 1996-2004

The initial goal of the CPBG was to improve the health status of the target populations: women of childbearing age, pregnant and lactating women, newborns and infants, and focus on increasing positive birth outcomes by way of providing services and education to all women of childbearing age prior to, during, and after childbirth. The suggested strategies to achieve this goal are as follows:

- Promote programs that address the health status of the target population prior to conception
- Promote/encourage early pregnancy diagnosis and enrollment in a prenatal care program
- Provide quality prenatal care to the target population
- Build, improve and/or expand a health system that provides comprehensive prenatal health care services to the target population in each county

The uniqueness and flexibility of this program allows each county to determine their own needs based on an annual needs assessment. Planning and implementation of the program are done at a local level. Each county regards the CPBG as their local Maternal Child Health Program patterned after OWCH maternal child health goals. Without this grant, most counties would not have a Maternal Child Health Program or be able to provide any of the needed services.

Utilizing the Logic Model, the CPBG is now able to identify the actual numbers of women and children who have benefited from the program, as well as actually measure effectiveness of the services provided. In 2002, the Logic Model was required to be used by all counties as the planning, evaluation and reporting tool for this program.

## **II. 2004-2005 CPBG SUMMARY**

### **A. County Summaries and Evaluations**

The County Summaries section contains a summary of each county's location, description, activities and program accomplishments. Following the summary is the evaluation, by county, and is provided in a matrix format that consists of each goal, the objectives used to achieve the goal and the evaluation that reports or measures the accomplishments of the objectives. The objectives state an estimated number of participants that counties anticipate reaching. The evaluation column reports the actual numbers reached.

Each county has reported its goals, objectives and evaluations. Since each county develops programs and services based on local needs assessments, goals and objectives vary from county to county. This results in an extremely wide range of activities and services. For example, one county may have identified the number of teen pregnancies as a priority, while another county may have identified lack of available prenatal care services as a priority. Overall, services that are common to most counties consist of prenatal classes, childbirth education classes, breastfeeding education, risk assessments, home visits/case management, folic acid education and supplements, preconceptional health, pregnancy tests and referrals to family planning services. There is also a strong focus on childhood immunization and child safety programs.

## **B. Statewide Aggregate Evaluation**

This section reports aggregate numbers of all 15 counties. Four major goals have been identified:

- Improve birth outcomes for infants born in the state of Arizona
- Increase access to mental health services for pregnant or postpartum women
- Reduce the incidence of childhood diseases, avoidable injuries and infant mortality
- Improve the infrastructure of the perinatal services delivery system

## **C. Additional Programs**

Based on the individual needs assessments that were conducted by each county, there were other areas of service delivery that were identified, not common to all counties, but are very important to mention:

- Substance abuse information and education was provided to pregnant women and teens
- Lending libraries provided tapes, books and other sources of educational materials for community, school and agency use
- Prenatal classes for Spanish-speaking women only provided in areas where language was identified as a major barrier

## **D. Coordinated Programs**

Due to the uniqueness and flexibility of the CPBG program, counties are able to utilize funds to enhance and expand other programs. For example, some counties utilize pregnancy tests to identify women early into the pregnancy in order to increase the likelihood that they receive prenatal care as early as possible. If the test is negative, they utilize this opportunity to educate women on family planning options as well as the importance of folic acid. Most counties also provide them with folic acid supplements. While the Arizona Department of Health Services funds the folic acid program, many counties choose to supplement it with CPBG funds so that more women are served.

In many cases, the Health Start (HS) staff provides services (i.e. home visits, identification of potential at-risk women, home-safety checks and car seat education) to both CPBG clients and HS clients. They are, therefore, able to identify women who may not be eligible for one program (HS) but are eligible for the other (CPBG). Their salaries are taken from both grants when appropriate. In areas where the county has no Health Start, the CPBG program functions much like it.

Immunizations tend to be not only a major concern for the counties, but are also a way to provide some of the postpartum services of the county health departments. Their target population is “infants up to the age of two years.” Consequently, this gives CPBG staff the opportunity to do assessments on the needs of the home and

family including postpartum depression, home-safety issues, medical assessments for the newborn and referrals to the family planning program.

The car seat program has become a major effort in all 15 counties. A few of the counties are funded through the Community Health Grants to provide this program. However, there are a number of counties that do not receive funds elsewhere and are utilizing the CPBG funds to provide this service. They have had staff trained as technicians to conduct car seat inspections, purchase car seats and provide families with proper training on car seat safety and installation.

## **E. CPBG and Maternal Child Health Programs**

In the majority of the counties, the coordinators are also public health nurses and tend to wear several hats—working in immunizations, pregnancy testing clinics, family planning, and child health programs. The two budget reductions this program has experienced forced the counties into taking a synergistic approach to program planning, service delivery and budgeting. The CPBG is used to supplement a number of programs that address the same target populations that this grant is mandated to address. The flexibility of this program allows creative use of the grant funds to keep women and children from falling through the cracks or being excluded based on certain criteria. In other words, funding or supplementing programs for women and children who may not be otherwise qualified in one program may make them eligible to receive services in another.

## **III. PROGRAM DESCRIPTION**

This program is unique in both structure and process. Unlike most traditional grants, the CPBG is county driven and community based. Each county determines what is needed in the community. OWCH has supported the communities identifying their own community needs and acting on their own solutions. Because of this, the descriptions of the programs vary from county to county. However, there are four fundamental goals that are consistent throughout all counties: 1) improve birth outcomes for infants born in Arizona 2) increase access to mental health services for pregnant or postpartum women (3) reduce the incidence of childhood diseases, avoidable injuries and infant mortality, and (4) improve the infrastructure of the perinatal services delivery system. Each county health department (CHD) holds advisory board meetings to develop a needs assessment and implementation plan. They are revised annually and are the tools used to develop, implement and evaluate programs that will improve the health of women, children and infants. This process requires all counties to do the following:

- Include significant participation and involvement of community membership in the planning process
- Identify local needs and compare to statewide and national needs
- Develop a system of coordinated service delivery
- Collaborate with other local agencies to coordinate services

## IV. PROGRAM BARRIERS

### A. Staffing

Most of the counties are rural, which has presented a significant problem in staffing the CPBG programs. It is not only difficult to recruit qualified workers, it is almost impossible to retain them. . Because the funding formula is partially based on population, the rural county allocations are not adequate to meet the high cost of salaries, transportation barriers, and delivery of perinatal services throughout the county.

### B. Funding

Funding limitations have presented service barriers to all counties. The grant size has decreased since its inception in 1996 (see Figure 1, page 3). However, the population and target group have grown (Figure 2). As mentioned above, staffing problems and transportation barriers are common to all rural counties. In addition, some of the rural counties have no birthing hospital or physician. While the urban areas have a larger population that produces a greater number of providers, the needs usually far exceed available services, resources, and providers.

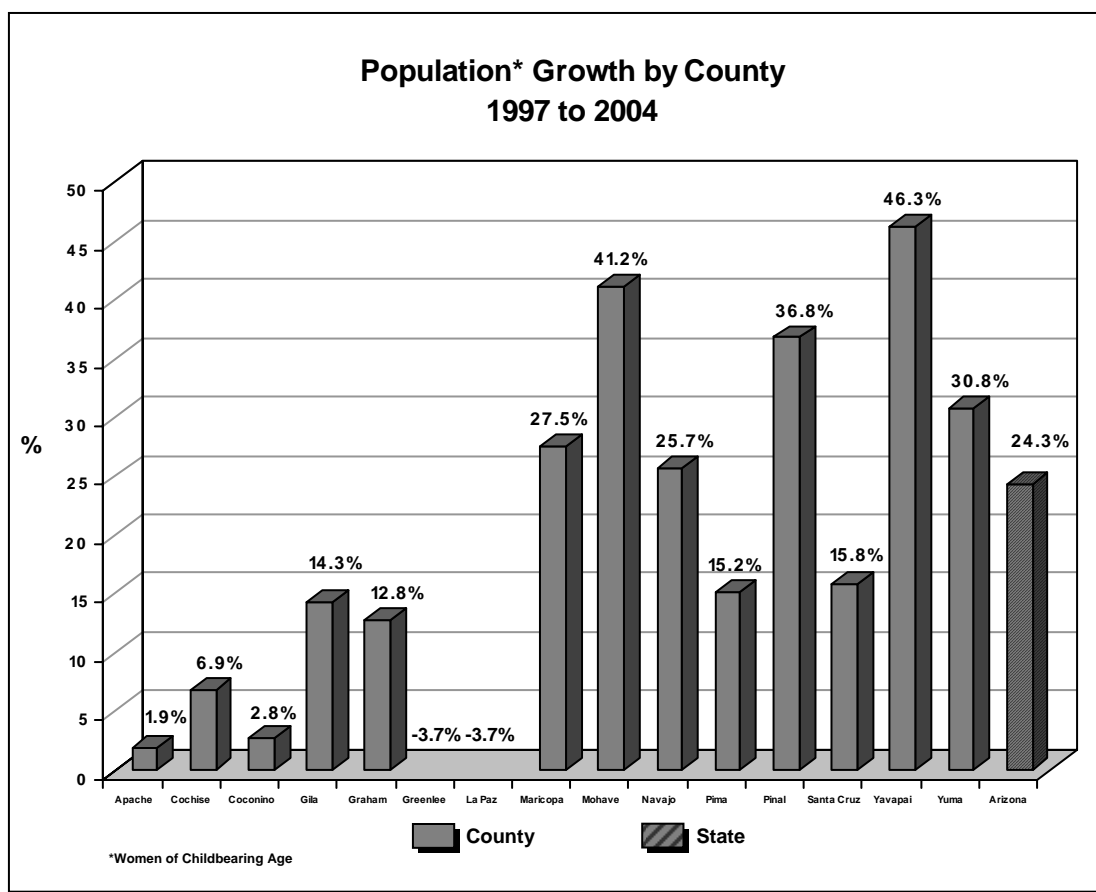


Figure 2 Source: Arizona Health Status and Vital Statistics 1996-2004

## V. COUNTY PRENATAL BLOCK GRANT – COUNTY REPORTS

### A. Apache County

Apache County is a rural community that lies in the northeastern area of Arizona with a population that has grown from 69,423 residents to 70,625 residents over the past year. Because the northern area of the county is on reservation land, the CPBG has been primarily servicing the southern Apache County area. The CPBG Program Coordinator has combined programs and resources to develop a comprehensive perinatal program addressing the needs of women, infants and children in Apache County. The Apache CPBG provides the following services:

1. **Prenatal Case Management Program:** The Apache County Health Department (ACHD) has used “creative financing” to develop and provide a comprehensive maternal child health program that addresses a full spectrum of services for women’s health, prenatal care and education, childbirth education, postpartum care, and children’s services. The CPBG Program coordinates services with other ADHS-funded programs such as Health Start Prenatal Outreach, Community Health Injury Prevention Programs, Women, Infants, and Children (WIC), and Family Immunization Clinics to provide the best possible services for clients. The CPBG staff provides prenatal classes and assistance to prenatal care, postpartum follow up, developmental assessments, and immunizations. Free car seats and car seat training are also provided to women who attend prenatal classes.

They work closely with Arizona Early Intervention Program (AZEIP), WIC, local health care providers, and public health nurses to ensure there is a “safety net” for women and children who would not otherwise receive services. For the women who are not qualified to receive Health Start services, Lay Health Workers provide the same assessments, follow-up services and referrals using the Health Start format. Because there is no birthing hospital in the county, and only one obstetrician and a part-time pediatrician in Apache County, the CPBG staff work hard to supplement and follow-up on clients to compensate for the lack of available medical services in the county.

2. **Child Safety Program:** Education materials were also distributed to the general community on Shaken Baby Syndrome and Sudden Infant Death Syndrome (SIDS). In addition, the CPBG Program provided education and assessments related to environmental hazards and in-home safety issues to pregnant women and families.

## APACHE COUNTY PROGRAM EVALUATION

### Goal 1: Increase positive birth outcomes by promoting early prenatal care

Objectives:	Evaluation:
1.1 By June 30, 2005, 60 pregnant women will be enrolled in the prenatal outreach program, as measured by client encounter forms.	1.1 - 74 women were enrolled in the prenatal outreach program.
1.2 By June 30, 2005, 200 prenatal visits will be provided by ACHD staff, as measured by prenatal encounter forms.	1.2 - 260 visits were provided by staff.
1.3 By June 30, 2005, 75 pregnant women will be referred from local social services agencies into the prenatal outreach program, as measured by monthly reports.	1.3 - 80 women were referred into the program.

### Goal 2: Increase the knowledge of new mothers of newborn/infant care

Objectives:	Evaluation:
2.1 By June 30, 2005, 50 children under the age of 2 years will receive age-appropriate immunizations, as measured by information on family follow-up forms.	2.1 - 225 children received age-appropriate immunizations.
2.2 By June 30, 2005, 50 children will be assessed using the Ages and Stages questionnaire, as measured by the family follow-up form.	2.2 - 145 children were assessed.
2.3 By June 30, 2005, clients will be provided with six classes relating to nutrition, breastfeeding, labor/delivery, home safety and parenting, as measured by class sign-in sheets.	2.3 - 30 classes have been held.

<b>Goal 3: Improve the knowledge of women of childbearing age regarding the importance of women's and prenatal health</b>	
<b>Objective:</b>	<b>Evaluation:</b>
3.1 By June 30, 2005, women of childbearing age that are enrolled in the prenatal outreach program will demonstrate a 60% increase in knowledge related to the importance of women's and prenatal health for positive birth outcomes, as measured by pre/posttest results.	3.1 - 60% increase in knowledge was demonstrated.

## B. Cochise County

Cochise County is located in the southeastern corner of Arizona with a population that has grown from 117,755 residents to 126,160 residents over the past year. The CPBG functions under the project name of the Adolescent, Maternal and Child Health Project (AMCH) within the Cochise County Health Department (Cochise CHD). The CPBG Coordinator also oversees the Health Start Program and has combined resources that have resulted in an excellent perinatal program that covers a very large, rural area.

**1. Prenatal and Preconceptual Health Program:** Teen pregnancy is a major priority for the Cochise CPBG Advisory Board. Although teens are a priority in Cochise County, all services are available to women of childbearing age. Major functions of the program are devoted to case management, perinatal services and education to these populations:

- Education:  
Linkages and collaboration with other programs, schools, and agencies provide opportunities for Lay Health Workers to educate teens on issues related to puberty, health status and the effects they have on birth outcome (prior to and during pregnancy). The importance of breastfeeding and its impact on a child's health is also stressed.
- Car Seat Program:  
Car seat safety classes and free car seats are also provided to families and day care providers through two programs. They have collaborated with the Cochise Network Association (CNA) funded by the ADHS Community Health Grant. Currently they receive car seats and the Lay Health Workers provide education. In addition, a private foundation assists in funding a car seat program in northern Cochise County. In both cases, Cochise CHD/CPBG Program staff provides the training and education for installation and proper use by certified technicians.
- Folic Acid:  
Folic acid education, supplements and follow up appointments are provided to women who are not pregnant. Funding for the educational and follow-up components is no longer available through ADHS. Cochise CHD has been providing these services through the CPBG program and they are looking for future funding for the supplements in the event ADHS is no longer able to provide them.

- **Lead Poison Program:**  
Due to collaboration with the County Housing Authority, Cochise CHD provides lead poisoning testing and education to homes of clients who reside in target areas. Finger stick screenings for lead testing are provided for infants at the ages of 12 months and 24 months. In cases where lead poisoning exists, the housing authority will remodel the home to remove lead paint.
- **Case Management:**  
Lay Health Workers provide prenatal care and childbirth education and support to pregnant women. However, the Cochise CPBG Advisory Council has identified teen pregnancy as a priority. While efforts are made to serve the teenage population, no one is turned away and services are provided to all women of childbearing age in Cochise County. Breastfeeding education is provided with explanation of the effects of formula feeding versus breast milk and the health impact on infants. Home visits are made before and after childbirth providing the support they may need related to oral health, preterm delivery, parenting, child care, home safety, stages of development and education on the effects drugs and alcohol have on birth outcome. There is also an emphasis on continuing their education and planning for their future.

Cochise CHD is also a Health Start provider that provides many of the same services identified above. However, in many cases their participants are not eligible for Health Start. The CPBG program utilizes Health Start service level criteria and documentation for non-Health Start participants. The CPBG program provides all of the reported services in addition to Health Start without duplicating services or clients.

2. **Breastfeeding Program:** Lay Health Workers have been trained in breastfeeding counseling. Much of their efforts are focused on education and research on negative side effects of formula fed babies. They are now providing breastfeeding classes as a part of the prenatal classes offered at the hospital. Breastfeeding classes are also a component of the case management/home visit program.
3. **Oral Health Program:** Since the CPBG staff is aware that there is a significant correlation between periodontal disease and preterm deliveries, an oral health component has been added to their program of services. The childbirth education class participants are provided with Koolerz Gum containing xylitol and information on how to prevent dental caries.
4. **Community Collaboration:** Cochise CPBG continues their extensive collaborative efforts with the Cochise Network Association, the Cochise County Housing Authority, the Southeastern Area Behavioral Health Service and other local agencies and providers to develop and expand programs and systems of care that will result in an efficient system to better meet the needs of area residents.

## COCHISE COUNTY PROGRAM EVALUATION

### Goal 1: Improve pregnancy outcomes for women of childbearing age

Objective:	Evaluation:
1.1 By June 30, 2005, 300 women will be educated on folic acid, as measured by client chart.	<p>1.1 - 319 women will be educated on the importance of folic acid.</p> <p>97% of the women demonstrated an increase in knowledge of the importance of folic acid.</p> <p>Although this program is funded by ADHS, there is no adequate funding for the educational component and program coordination. Consequently, CPBG funds are used to supplement this program.</p>

### Goal 2: Reduce negative outcomes of teen risk-taking behavior

Objective:	Evaluation:
2.1 By June 30, 2005, 200 teens will be educated on puberty, maturation, sexuality and pregnancy, as measured by evaluation forms.	2.1 - 403 teens were educated.

### Goal 3: Reduce the number of deaths to children caused by motor vehicle crashes

Objective:	Evaluation:
3.1 By June 30, 2005, 200 families will receive car seat safety training and education on car seats, as measured by car seat installation forms.	3.1 - 175 families and caregivers received car seat training directly from Cochise County Health Department CPBG staff.

<b>Goal 4: Reduce the number of preventable injuries caused by poisoning and death in home incidents</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
4.1 By June 30, 2005, 100 families will receive safe home-safety devices, as measured by the checklist tool.	4.1 - 65 families received safe-home visits.
4.2 By June 30, 2005, 200 pregnant women and children will be tested for lead exposure, as measured by lead samples.	4.2 - 210 pregnant women and children have been tested for lead poisoning.

## C. Coconino County

Coconino County, which covers the largest area of all Arizona counties, lies in the northern area of Arizona. The county covers more than 18,000 square miles, and has a population that has grown from 128,925 residents to 129,570 residents over the past year.

The CPBG Coordinator has done an excellent job expanding the program, collaborating with other community resources and developing and implementing very creative programs that address the issues of the women in Coconino County. The Manager of Access to Health has also demonstrated much support and interest in the success of the program.

1. **Prenatal Care Program:** The Coconino County Health Department (Coconino CHD) has partnered with North Country Community Health Center, the local community health center, to implement a program that would encourage and facilitate early prenatal care for women who are economically disadvantaged (incomes with 200% of the federal poverty level or less, have no insurance and are not receiving Arizona Health Care Cost Containment System (AHCCCS) benefits.

Coconino CHD provides a \$300 payment for pregnant women who meet income guidelines to supplement the prenatal care package that the health center offers. This program has been so effective in the past that North Country Community Health Center has also procured funding of its own from other sources to provide this service. When their resources are no longer available, the CPBG program funds the balance of the year, assuring that all women who qualify will receive prenatal care. The CPBG program's collaboration with North Country now has the database resources to measure the effect of early prenatal care on birth outcome.

### 2. Maternal Child Health Programs:

- **Childbirth Series:**  
The CPBG Program has developed and coordinates a comprehensive series of classes to help prepare both "parents-to-be" for labor, delivery and life with their baby. All of the classes are held once a month and are free of charge.
  - ▶ **Perinatal Fitness:**  
This class helps pregnant women develop a healthy nutrition and exercise plan, from the beginning of their pregnancy to six months after delivery. The class includes a balance of nutrition and education, strength training, stretch/relaxation, and moderate exercise.
  - ▶ **Childbirth Education Workshop:**  
The Workshop is a six-hour class that prepares expecting parents for labor and delivery. The class covers stages of labor, relaxation techniques,

massage, and common medical procedures during childbirth. For the expecting mothers, the last hour and a half includes guided relaxation exercises while the fathers participate in “Boot Camp for Dads” (See below).

▶ “Boot Camp for Dads”:

“Boot Camp for Dads” is a program educating new fathers about infant care and bonding. This class brings together expecting fathers and new fathers and their infants to discuss the basics of life with the new mother and baby.

▶ “Hello Baby”:

This is an introduction to newborn care covering diapering, bathing, breast and bottle feeding, sleep and awake patterns, personality and development, crying and colic, illness and doctor visits and the new mother taking care of herself.

▶ Couples Skills for Parents:

To complete the Childbirth Series, a class that focuses on improving communication skills for the new parents, is also offered. The class is offered free of charge for couples who have taken, or plan to take, the childbirth education class.

• Breastfeeding Program:

The CPBG Coordinator has been assisting the WIC program in the development of a Breastfeeding Peer Counseling Program. Funding needed to hire a coordinator has recently been procured. A woman who has been a breastfeeding mother and is aware of the state social services system will fill the position.

The CPBG Coordinator has also been actively involved in assisting the Arizona Breastfeeding Coalition in developing a breastfeeding supportive workplace policy in Coconino County. Efforts are also being made to approach businesses to adopt a breastfeeding supportive workplace policy.

3. **KidStuff Swap:** This very unique program allows families to trade outgrown clothing and baby items with other families. It is also intended to provide families with the opportunity to receive information and appropriate referrals for health and social services in their community. Events are held in both Page and Flagstaff.
4. **Teen Maze:** A two-day Teen Maze event was held in Flagstaff in which 481 students attended. The Maze covered topics such as sexual activity, substance abuse, poor nutrition, physical inactivity and violence. A second event is planned in the fall in Page. Forty students attended from the Page area to determine if a second event would be beneficial. The students in attendance found it very

educational and an experience they would very much like to see in the Page area. Overall, it was a very successful event.

5. **Women's Behavioral Health Issues:** As a result of the 2004 Needs Assessment, women's behavioral health issues were identified as a major priority. Consequently, the CPBG Coordinator held women's and children's health focus groups. Access to medical care was a common theme across most focus groups. However, when asked what makes women healthy, domestic violence and mental health (stress, substance abuse and negative emotional state) were the most frequently identified barriers. In response to this information, the CPBG Program is coordinating community meetings among those who serve these populations. The meetings are to map out the current continuum of care for women in domestic violence situations and/or women with behavioral health needs, identify strengths and weaknesses, and foster community collaboration to meet common goals.

## COCONINO COUNTY PROGRAM EVALUATION

### Goal 1: Improve birth outcomes among low-income women through prenatal care and prenatal education

Objectives:	Evaluation:
1.1 By June 30, 2005, 90 low-income couples will receive childbirth education through free classes, as measured by class sign-in sheets.	1.1 - 88 couples attended childbirth education classes.
1.2 By June 30, 2005, 85 couples will correctly identify how to react to symptoms of preterm labor, as measured by posttests.	1.2 - 75 couples demonstrated increase in knowledge.
1.3 By June 30, 2005, class participants will show 15% increase in knowledge of childbirth, as measured by pre/posttests.	1.3 - 12% average increase in knowledge was demonstrated.
1.4 By June 30, 2005, 20 pregnant women will receive perinatal fitness education, as measured by sign-in sheets.	1.4 - 12 pregnant women attended classes.
1.5 By June 30, 2005, 15 participants served in Objective 1.4 will report that they are more likely to engage in regular prenatal exercise, as measured by participant survey.	1.5 - 12 women (100%) reported that they would participate in regular prenatal exercise.  NOTE: Due to low enrollments, this class was discontinued in June 2005.
1.6 By June 30, 2005, 74 uninsured pregnant women living under 200% of the Federal Poverty Line will receive prenatal care for \$300 at Northland Community Health Center clinic, as measure by clinic invoices.	1.6 - 84 clients received financial assistance for prenatal care.

1.7 By June 30, 2005, 44 of the women in Objective 1.6 will enter prenatal care during the first trimester, as measured by patient records.	1.7 - 36 women (42%) entered prenatal care in the first trimester.
<b>Goal 2: Increase parenting and infant care skills among expecting mothers and fathers</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
2.1 By June 30, 2005, 72 expecting dads will receive infant care and bonding education through monthly Boot Camp for new Dads classes, as measured by class sign-in sheets.	2.1 - 52 dads participated in the program.  NOTE: Due to poor weather conditions in January and March, Boot Camp classes were cancelled resulting in reduced number of anticipated participants.
2.2 By June 30, 2005, 80% of dads participating in the program will report improved confidence on at least 4 of 7 infant care and bonding skills, as measured by participant evaluations.	2.2 - 46 dads (88%) reported improved confidence on at least 4 of 7 skills.
2.3 By June 30, 2005, 60 expecting couples will receive infant care education, as measured by class sign-in sheets.	2.3 - 60 expecting couples participated in classes.
2.4 By June 30, 2005, participants will demonstrate a 15% increase in knowledge related to infant care, as measured by pre/posttests.	2.4 - 5.5% increase in knowledge.  NOTE: Due to class format, some participants did not complete the pre/posttest. The CPBG Coordinator is working with the class instructor to improve completion rates so knowledge assessment can be more accurate.
2.5 By June 30, 2005, 40 expecting parents will participate in a communication workshop designed for new parents, as measured by class sign-in sheets.	2.5 - 52 parents (26 couples) attended classes.

<b>Goal 3: Increase utilization of MCH-related education and services</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
3.1 By June 30, 2005, a collaborative outreach event (Kidstuff Swap) will provide at least 125 families in Coconino County with information on at least 6 local health and social services, as measured by participant evaluations.	3.1 - 102 families attended. 7 service agencies participated. 3 events were held.
3.2 By June 30, 2005, 41 families will be referred into an appropriate health or social service, as measured by evaluations completed by participating service agencies.	3.2 - 65 families were referred to services.
3.3 By June 30, 2005, all CPBG Advisory Board members and e-news subscribers will receive a quarterly CPBG e-newsletter with updates on MCH-related services, as measured by completed e-mail list.	3.3 - 4 e-newsletters were distributed. The e-newsletter now connects over 60 MCH providers across Coconino County.
3.4 By June 30, 2005, 30 MCH professionals will participate in a low-cost training on how to market health and social services to women and infants, as measured by registration sheet.	3.4 - 29 individuals attended the workshop.
3.5 By June 30, 2005, 90% of participants will indicate that they learned at least 3 skills they will use to better market their services to women and infants, as measured by evaluations.	3.5 - 17 individuals completed evaluations, 14 (82%) indicated they earned 3 skills to better their services to women and infants.

<b>Goal 4: Increase breastfeeding initiation and duration rates</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
4.1 By June 30, 2005, four Arizona Breastfeeding Coalition, Northern Region (ABCNR) meetings will be held, as measured by meeting minutes.	4.1 - 4 ABCNR meetings were held.
4.2 By June 30, 2005, four employers in Coconino County will adopt a breastfeeding supportive workplace policy, as measured by certificates of recognition.	4.2 - 4 Employers developed a breastfeeding supportive workplace policy: NAU, City of Flagstaff, NARBHA and Women Care Midwifery.
<b>Goal 5: Increase the proportion of pregnancies begun with an optimal level of folic acid</b>	
<b>Objective:</b>	<b>Evaluation:</b>
5.1 By June 30, 2005, 400 low-income women of childbearing age will receive folic acid education and free multivitamins, as measured by program summary reports.	5.1 - 191 women received supplements and education.  NOTE: Although this program is funded by ADHS, there is no adequate funding for the educational component and program coordination. Consequently, CPBG funds are used to supplement this program.
<b>Goal 6: Increase the proportion of teenagers who engage in healthy behaviors</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
6.1 By June 30, 2005, 700 teen students will participate in a Teen Maze that emphasizes preconceptual health issues and consequences of substance abuse, poor nutrition, physical inactivity and violence, as measured by Teen Maze sign-in sheets.	6.1 - 870 teens participated.

6.2 By June 30, 2005, participants in the Teen Mazes will demonstrate an (performance index) increase in knowledge of 25% on issues related to (preconceptual) health care, as measured by posttest and control group comparison.	6.2 - 36% (performance index) increase in knowledge.
6.3 By June 30, 2005, 560 Teen Maze participants will agree or strongly agree with the statement, "I think the Teen Maze experience will help me make healthier choices in the future," as measured by posttests.	6.3 - 780 teens reported the Teen Maze will help them make healthier choices.

## D. Gila County

Gila County is located in the central area of Arizona with a population that has grown from 53,555 residents to 54,060 residents over the past year. The major portion of the population lives primarily in small rural areas. The majority of the county resources are in the Globe/Miami and Payson areas.

1. **Educational Programs:** One major focus for Gila County Health Department (Gila CHD) has been to provide informational materials to the public regarding nutrition, oral health, prenatal care, breastfeeding, folic acid, and birth defects. Community members, as well as local agencies, also have access to the lending library that consists of videos and books on child development, prenatal care, parenting, curricula on hygiene, water safety, etc. Although the library was initially developed for the county clients and the general public, schools, college students and other agencies have found it to be a valuable source of information and its resources are used primarily as teaching tools. The CPBG Coordinator searches for new books, brochures and films to keep the educational materials current.
2. **Community Workshops:** The CPBG Coordinator has developed a prenatal educational curriculum and training workshops. Workshops include information on conception, prenatal care, breastfeeding, labor and delivery, infant care, shaken baby syndrome, child safety and folic acid.

The CPBG Coordinator also participates in monthly workshops that include car seat training, fire safety and oral health. She also provides educational opportunities via newspaper articles, advertisements and interviews on the local radio station on issues related to prenatal care and preconceptual health.

3. **Teen Educational Program:** The CPBG Coordinator provides one-on-one education to high school teens utilizing the “Baby Think it Over” program. In addition, she educates them on prenatal issues, fetal development, delivery, newborn care, budgets and life issues.

This year a Teen Maze was also provided in Globe. A total of 157 students attended the maze, including students from the Payson area. Evaluation results indicate a positive outcome with strong encouragement for Gila CHD to sponsor again next year.

4. **Network and Collaboration Activities:** The CPBG Coordinator is actively involved in a number of maternal and child health organizations. Her involvement includes participation in the Early Childhood Network, Horizon, Child Protective Services, WIC, Department of Economic Security (DES) Child Care, Head Start, Tobacco Free Environment, the local hospital, Healthy Mothers/Healthy Babies Coalition, and the Globe/Miami Interagency meetings.

5. **Child Safety Program:** The CPBG Coordinator has received car seat technician training and provides education and inspection services to eligible families. She has also been providing free car seats when they are available.
6. **Emergency Services:** As a special service to families who are in crisis and need, the CPBG coordinator has recruited donations from community sources to provide emergency formula, diapers and clothing. This program is not advertised as demand may exceed supply.

The Coordinator has also expanded the service area to include outreach to Payson, Hayden, Winkleman, Pine, Strawberry, Tonto Basin, Roosevelt, as well as Globe and Miami.

7. **Health Start Grant:** The CPBG Coordinator is also coordinating the Health Start Program and has hired a Lay Health Worker. As a result, Health Start clients have been made aware of the services of the CPBG Program and have been able to benefit from both programs.

## GILA COUNTY PROGRAM EVALUATION

### Goal 1: Reduce risk of poor birth outcomes for families in Gila County

Objectives:	Evaluation:
1.1 By June 30, 2005, 500 resource and educational materials pertaining to prenatal care, prenatal resources, nutrition and folic acid will be developed and disseminated to families and women of childbearing age in Gila County, as measured by resource inventory.	1.1 - 1,399 educational materials were disseminated at Miami Head Start Kindergarten Roundup, Public Divisional Maze, San Carlos Wellness Conference, Globe Head Start Kindergarten Roundup, and the Payson Craft Fair.
1.2 By June 30, 2005, five new materials for the lending library will be provided to agencies, community groups and women in Gila County, as measured by lending library inventory.	1.2 - 16 new educational materials related to labor and delivery, breastfeeding, pregnancy, infant and child care were purchased.
1.3 By June 30, 2005, 30 pregnant and postpartum women will attend a workshop related to prenatal care, breastfeeding, folic acid, fetal development, child safety, infant care and hygiene, as measured by sign-in sheets.	1.3 - 47 pregnant and postpartum women attended workshops.
1.4 By June 30, 2005, workshop participants will demonstrate a 25% increase in knowledge on issues related to prenatal care, breastfeeding, folic acid, fetal development, child safety, infant care and hygiene, as measured by pre/posttests.	1.4 - Workshop participants demonstrated a cumulative average of 38.41% increase in knowledge.
1.5 By June 30, 2005, women of childbearing age in Gila County will be provided with two multimedia prenatal education opportunities, as measured by newspaper articles or radio scripts.	1.5 - 13 multimedia prenatal educational opportunities were provided via newspaper articles and local radio talk show appearances by the CPBG Coordinator.

<b>Goal 2: Improve health status and safety of newborn infants and children in Gila County</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
2.1 By June 30, 2005, 20 child safety restraints and applicable trainings will be provided to eligible Gila County residents, as measured by number of car seats and signed waivers.	2.1 - 22 trainings were provided and car seats were provided.
2.2 By June 30, 2005, participants in the car seat program will demonstrate a 20% increase in knowledge related to the importance and use of car seats, as measured by pre/posttests.	2.2 - There was a cumulative 27.5% increase in knowledge.
2.3 By June 30, 2005, 150 teens will attend classes related to prenatal education, sexually transmitted disease education, parenting and newborn care, as measured by evaluation surveys collected.	2.3 - 189 teens attended classes.
2.4 By June 30, 2005, six public workshops will be provided to Globe/Miami residents on safety, self-improvement and health topics, as measured by flyers and sign-in sheets.	2.4 - 6 workshops were held.

## E. Graham County

Graham County is a rural county located in the southeastern area of the state. The county has a population that has grown from 34,490 residents to 36,020 residents over the past year.

The staff responsible for carrying out the duties of the CPBG Program have developed and maintained a very successful and productive Maternal and Child Health Program. The CPBG Coordinator and the Director of Nursing (DON) are very intent on providing quality care to pregnant women in Graham County. The current Coordinator has been in this position for over a year and has contributed to creating a very stable program that appears to be revitalized, providing prenatal classes, useful incentives, and collaboration with other agencies.

1. **Pregnancy Testing and Counseling:** Pregnancy Testing Clinics continue to be held two times a week. Pregnancy testing is also available by appointment and on a walk-in basis. All who test positive receive counseling related to family planning options, resources, pregnancy and prenatal care as well as appropriate referrals to WIC, AHCCCS and Graham County Health Department (Graham CHD) prenatal classes. They also receive a congratulatory bag with information about pregnancy and a 90-day supply of multiple vitamins.
2. **Community Involvement and Education:** The Graham CHD and the CPBG Program participated in a Teen Health Fair/Maze. Over 536 students were provided with information on signs and symptoms of sexually transmitted diseases (STDs) and treatments available. This event was held in collaboration with the Graham CHD, Teen Pregnancy Prevention Initiative, Teen Wellness Clinic, Child and Family Resources and the 4H Character Development Program.
3. **Folic Acid Program:** Women who have a negative pregnancy test result receive family planning information and folic acid education. They are also provided with up to a year's supply of supplements. A major objective for Graham County is to increase women's knowledge of the importance of their health status prior to pregnancy, and its effect on birth outcome. The Folic Acid Education Program has also been extended to include the community college courses in nursing and nutrition. Prior to this year, folic acid supplements and a monthly stipend were provided from ADHS. The grant was not adequate to meet the training/education component and the CPBG funds were used to supplement it. As of this current year, ADHS will provide folic acid supplements only as long as their supply lasts. Graham CHD plans to continue this program as a component of the CPBG program.
4. **Prenatal Education:** The CPBG Coordinator is continuing to collaborate with the Nutritionist to provide prenatal classes that coincide with the nutrition classes that are provided to WIC clients. Prenatal classes are also offered to any woman who presents at the Graham CHD clinic. The CPBG Coordinator has developed curriculum and provides classes on cold and flu prevention, HIV awareness,

periodontal disease and preterm labor, postpartum depression, keeping healthy during pregnancy, immunizations, West Nile Virus, lead poisoning, anemia and Arizona venomous creatures. All classes are geared toward prenatal care and/or care of the newborn.

An excellent incentive program has been developed that includes monthly drawings for attendees. Gift packs containing useful and practical items that new mothers need and many times cannot afford are included in this drawing. Developing this program in conjunction with WIC has been extremely successful so far, and women are demonstrating increased awareness of the importance of nutrition and prenatal care. This appears to be a much needed and wanted program in Graham County.

## GRAHAM COUNTY PROGRAM EVALUATION

### Goal 1: Increase likelihood of ensuring a positive birth outcome

Objectives:	Evaluation:
1.1 By June 30, 2005, a minimum of 100 women who test positive for pregnancy will leave with prenatal vitamins, educational material, and community resources, as measured by clinic records and patient files.	1.1 - 115 women tested positive for pregnancy and received prenatal information and prenatal vitamins.
1.2 By June 30, 2005, 100 pregnant women will attend the prenatal education classes, as measured by class sign-in sheets.	1.2 - 188 pregnant women have attended the classes.
1.3 By June 30, 2005, participants in the prenatal education program will demonstrate a 75% (performance index) increase in knowledge related to prenatal care, as measured by pre/posttest scores.	1.3 - Women demonstrated a 100% (performance index) increase in knowledge.
1.4 By June 30, 2005, 100 women who have negative pregnancy test will receive information on family planning services and on folic acid as well as a year's supply of supplements, as measured by client records.	1.4 - 128 women received information and/or supplements on folic acid and family planning services.  Although this program is funded by ADHS Office of Nutrition Services, there is no adequate funding for the educational component and program coordination. Consequently, CPBG funds are used to supplement this program.
1.5 By June 30, 2005, women who receive folic acid education will demonstrate a 75% (performance index) increase in knowledge of the importance of folic acid before conception, as measured by pre/posttests.	1.5 - Average pretest scores: 0% Average posttest scores: 100% 100% average increase in knowledge.

## **F. Greenlee County**

Greenlee County, located in the southeastern area of Arizona, is a small rural county bordering New Mexico. Greenlee's population has decreased from 8,595 residents to 8,350 residents over the past year

The Greenlee County Health Department (Greenlee CHD) has undergone a number of changes as well as staffing losses. The Director of Nursing (DON) resigned at the end of the last contract year. The position was filled shortly after and the program appeared to continue with the same efficiency and benefits as before. However, the replacement DON resigned after only a few months. Greenlee County is a very economically depressed county and usually has a very difficult time staffing vacancies, especially nurses. Fortunately, in the last two years, Greenlee County has been an excellent example of a rural community utilizing limited resources to provide a safety net for pregnant women.

### **1. Health Education and Prenatal Care Program:**

- **Prenatal Classes:**

The CPBG Coordinators have developed and implemented a comprehensive prenatal education program. Classes consist of six sessions, and many times include the baby's father and/or other family members. The curriculum covers health during pregnancy, stages of pregnancy through labor and delivery, nutrition, and cesarean births. It also includes books, films and one-on-one counseling/educational sessions.

CPBG Program staff developed a very collaborative relationship with the WIC worker. They refer clients to each other in order to ensure that pregnant women and new mothers receive a full range of services that are very accessible.

- **Pregnancy Testing Program:**

When a woman receives a positive pregnancy test, she immediately receives prenatal vitamins and a referral to WIC. Women will immediately receive education on breastfeeding as well as breast pumps. They also receive car seat safety training and child restraints. Since Greenlee County has no obstetrician and no hospital, for many women the CPBG program is the only prenatal care they receive. For others, it may be the only prenatal care they receive until the third trimester. Each year, the Coordinator tracks birthweight for the current year to determine if, and by how much, her program has influenced birth outcome for these women as compared to last year's rates.

- **Tobacco Education:**

When appropriate, a referral is made for clients who smoke. A film and educational materials are provided to all prenatal clients. It includes information on the effects of tobacco, drugs, and alcohol on the unborn fetus.

- Folic Acid Program:  
When women have a negative pregnancy test, they are provided with folic acid education and supplements. They also receive information on family planning services. They are also provided with vitamins that have folic acid supplements even when they are pregnant for the first few weeks of development, when it is the most important.
2. **Gift and Information Packs:** When women receive a positive pregnancy test, they are given information packets that include information on prenatal care, immunizations, and community resources that are available. Gift packs are provided in carry tote bags and consist of Pamper Packs, Lamaze Packs, and extra flyers with labor and delivery and child care information, toys, parenting magazines, lotions, and other very helpful items. It is a major collection of useful items for a new parent that they may not be able to afford.

## GREENLEE COUNTY PROGRAM EVALUATION

### Goal 1: Improve birth outcomes for women of childbearing age in Greenlee County

Objectives:	Evaluation:
1.1 By June 30, 2005, 25 pregnant women will attend prenatal classes that provide education related to Labor and Delivery and Newborn Care, as measured by patient charts.	1.1 - 31 Pregnant women participated in prenatal classes.  Greenlee CHD also emphasizes fathers and extended family members in prenatal classes.  6 fathers and 4 extended family members participated.
1.2 By June 30, 2005, women in prenatal classes will demonstrate a 10% increase in knowledge regarding childbirth/prenatal care, as measured by pre/posttest scores.	1.2 - All participants demonstrated a minimum of 10% increase in knowledge.
1.3 By June 30, 2005, 100 women and teens will have been provided with educational materials, informational brochures, videos and literature on prenatal care, folic acid and sexually transmitted diseases, as measured by numbers of brochures and videos dispensed.	1.3 - 1,000 brochures were distributed.  3 Public Service Announcements were conducted.  1 Health Fair was attended by CPBG staff.
1.4 By June 30, 2005, 10 pregnant women and teens visiting the Greenlee CHD will receive supportive prenatal services in the first trimester, as measured by client files and intake forms.	1.4 - 33 women were seen by the CPBG Program in the first trimester. There is no doctor or hospital in Greenlee County. For many pregnant women, these may be the only prenatal services they will receive prior to delivery.
1.5 By June 30, 2005, 10 babies born from mothers who received prenatal classes in Greenlee County will weigh more than 5 lbs. 8 oz., as measured by client charts.	1.5 - 14 babies were born with a birthweight over 5 lbs. 8 oz. (12 babies were born in Greenlee County during 2004.)

## **G. La Paz County**

La Paz County, located in the western part of Arizona, is a rural county that has grown from a population of 19,715 residents to 21,135 residents over the past year. The CPBG Coordinator has also taken on the responsibility of Director of Nursing (DON). La Paz County Health Department (LPCHD) has had major problems recruiting nurses and consequently the CPBG Coordinator/DON has been the only nurse serving La Paz County. In spite of the staff shortage, she has been both creative and insightful regarding identifying the sources of the problems and solutions as well as creating effective programs to address the needs of the La Paz County women and children.

1. **Pregnancy Testing:** The CPBG Coordinator has developed a thorough assessment tool for women who receive pregnancy tests whether or not the results are positive or negative. This tool has been successful in determining pregnant women's eligibility for certain programs such as WIC, AHCCCS, Baby Arizona, etc. The tracking system developed by the CPBG Coordinator identifies, tracks, and refers not only women eligible for Baby Arizona but women who may be potentially eligible for other appropriate resources.

Pre/posttests have been developed for all educational services provided, including home safety checks and car seat training. LPCHD has an extremely well organized program that has an evaluation component reflecting accurate overall impact of the services they provide.

2. **CPBG/Immunization Program Partnership (Welcome Baby Basket):** The Immunization/Welcome Baby Basket program is targeted towards babies who are 12 months or younger. This program includes a home visit that is provided by the CPBG Coordinator and a Public Health Specialist. The increased success of this program could be because appointments are scheduled the same day as the application and are made within two weeks of the initial referral. The Basket contains practical items that the clients may not otherwise be able to afford. When the home visits are made, educational materials and information on programs (Kids Care, WIC, Baby Arizona, AHCCCS, etc.) are also provided. This program has four main functions:

- Limit the number of childhood diseases through the Immunization Program
- Assess home for safety concerns
- Identification of special needs for children (Developmental Assessments)
- Provide general information and education on parenting, nutrition, and community resources

The CPBG continues to be an outstanding program in spite of the fact that the LPCHD is very short on nursing staff. The CPBG Coordinator has made this a very productive and viable program.

3. **Folic Acid Program:** In spite of the cutbacks on Folic Acid, the LPCHD continues to provide folic acid education and supplements as well as information on family planning services for women who have a negative pregnancy test. Women are also being tested to ensure they have knowledge of the importance of taking folic acid.
4. **Car Seat Safety Program:** The CPBG Coordinator and her staff have participated in car seat technician training and are now certified. Car seat training and distribution takes place when the Welcome Baby Basket and home-safety-check visits are made. This has been a service of the LPCHD for a number of years but, until this year, has never been documented. The objective stated in the implementation plan now reflects the success of this program.

## LA PAZ COUNTY PROGRAM EVALUATION

### Goal 1: Improve birth outcomes for women of childbearing age in La Paz County

Objectives:	Evaluation:
1.1 By June 30, 2005, 160 women in La Paz County will receive pregnancy tests and information regarding women's health, and pregnancy/prenatal care, as measured by pregnancy test logs.	1.1 - 178 pregnancy tests were provided.
1.2 By June 30, 2005, 160 women who have a pregnancy test at La Paz County Health Department will be assessed for individual needs related to prenatal care and women's health, as measured by client assessment forms.	1.2 - 104 positive tests; 141 assessments were completed.  Referrals were made to Family Planning, Prenatal care, WIC, AHCCCS/DES, Medical Care and Tobacco Programs.
1.3 By June 30, 2005, women who test positive for pregnancy will demonstrate a 30% increase (performance index) in knowledge regarding pregnancy and prenatal care, as measured by pre/posttests.	1.3 - 95% (performance index) increase in knowledge was demonstrated.

### Goal 2: Reduce the number of childhood illnesses and injuries for children less than 2 years of age in La Paz County

Objectives:	Evaluation:
2.1 By June 30, 2005, 12 parents or guardians of babies 12 months of age or younger will be provided with information regarding safety, nutrition and child development, and will receive appropriate county and community referrals, as measured by the completed Welcome Baby Basket (WBB) Assessment forms.	2.1 - 25 parents or guardians received WBBs as well as information and appropriate referrals.

2.2 By June 30, 2005, parents or guardians will report a 20% (performance index) increase in knowledge regarding safety, nutrition, child development and referrals, as measured by completed WBB Forms.	2.2 - There was a 95% (performance index) increase in knowledge.
2.3 By June 30, 2005, 20 of all WBB will be delivered within a two-week time frame, as measured by the date on the referral from the date of the assessment.	2.3 - 24 of 25 WBBs were delivered within a two-week time frame.  Average delivery time: 4 days
2.4 By June 30, 2005, 20 parents/guardians will receive car seats, including information and education regarding car seat safety and installation as measure by car seat distribution log.	2.4 - 88 car seats were distributed.
2.5 By June 30, 2005, parents/guardians will demonstrate a 20% increase in car seat safety knowledge, as measured by pre/posttests.	2.5 - 92% (performance index) increase in knowledge.
<b>Goal 3: Increase positive birth outcomes by reducing neural tube defects</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
3.1 By June 30, 2005, 160 will receive education regarding the importance of folic acid and neural tube defects, as measured by pregnancy log records.	3.1 - 178 women received information and education regarding the importance of folic acid.
3.2 By June 30, 2005, women receiving information and education will demonstrate 60% (performance index) increase in knowledge of folic acid and neural tube defects as measure by pre/posttests.	3.2 - 95% (performance index) increase in knowledge was demonstrated.

## H. Maricopa County

Maricopa County, located in central Arizona, is the largest county in population in the state. Its population has grown from 3,072,149 residents to 3,524,175 residents over the past year.

The Maricopa County Maternal, Child and Family Health Division, as a result of the CPBG funding being reduced, has been forced to decrease staffing positions that have impacted the level and quantity of services and number of clients they are able to serve.

1. **Family Health Partnerships (FHP):** FHP is the component of the program that has been responsible for major community collaboration, coordination, partnering and coalition building in the South Phoenix and Maryvale areas. The Maricopa CPBG Program assists in the funding of this project that focuses on the mobilization of community coalitions and improvement of access to health care. Promoting self-sufficiency in communities, where services are lacking significantly, has become a very effective and creative means for communities to assume personal responsibility for prenatal care and services in their areas. One of the major focuses of FHP is the development and utilization of the Perinatal Periods of Risk (PPOR) model that is used to identify needs and health disparities for women of childbearing age in the Maryvale and South Phoenix areas. FHP is the driving force in the community infrastructure building of the Maricopa County Department of Public Health (MCDPH) which includes the Alliance for Innovations Health Care (Friendly Access survey) and the "It's A Baby's Life" program (see below).
2. **Pregnancy Connection:** The Pregnancy Connection is a comprehensive case management program for women who have a positive pregnancy test. Due to budget cutbacks, the Pregnancy Connection has been forced to be limited on the provision of direct services. Referrals are received from on-site pregnancy testing clinics, STD Clinics, Pregnancy Hotline, Planned Parenthood, Baby Arizona, Parent Support Center, Family Planning Program, the WIC Program, DES, schools and other agencies. Women with low-risk factors will be followed until they receive prenatal care. Those with high-risk factors will be referred to other programs, if possible, or will be followed by Pregnancy Connection staff if necessary. Most case management has been done by telephone while previously case managers provided at least three home visits during the pregnancy of high-risk clients. Because this program is totally funded by the CPBG, budget reductions have significantly affected services to at-risk pregnant women in Maricopa County.
3. **Community Development:** The CPBG/Office of Family Health has participated in the national Friendly Access project that focuses on the concept that good customer service improves access to care and increases the likelihood of women seeking prenatal care, which enhances the possibility of a positive birth outcome. Recently, funding was procured to conduct a friendly access survey that would

identify the barriers to care, customer service concerns and disparity issues specifically as they relate to the Maryvale and South Phoenix areas.

4. **"It's A Baby's Life"**: Partnering with Healthy Mother Healthy Babies, "It's A Baby's Life" is responsible for the recruitment and training of community mobilizers who are trained to provide education to the community on issues related to health and women of childbearing age. The primary focus this year has been on smoking cessation classes and how to approach smokers to encourage cessation.

## MARICOPA COUNTY PROGRAM EVALUATION

### Goal 1: Increase access to care in Maryvale and South Phoenix

Objectives:	Evaluation:
1.1 By June 30, 2005, strengthen the Alliance for Innovations in Health Care to assist with the implementation of the Friendly Access survey and development of a community plan by enlisting commitments of at least 15 members to complete coalition tasks, as measured by meeting notes.	1.1 - 19 Alliance members have taken on coalition tasks.
1.2 By June 30, 2005, adequate funding will be secured to implement the "It's A Baby's Life" community plan, as measured by award letter(s) from funder(s).	1.2 - MCDPH Tobacco program provided \$20,000 this year and a commitment for \$20,000 in 2005-2006.

### Goal 2: Decrease fetio-infant mortality in Maricopa County

Objective:	Evaluation:
2.1 By April, 2005, 20 stakeholders will commit to turning data into action, as measured by number of commitment cards.	2.1 - 20 Stakeholders submitted commitment cards.

### Goal 3: Increase access to prenatal care for women and teens receiving services at MCDPH and Pregnancy Connection Program

Objectives:	Evaluation:
3.1 By June 30, 2005, 400 pregnant clients referred to Pregnancy Connection Program will receive a pregnancy risk assessment and appropriate education and referrals for prenatal care, as measured by case management referral log.	3.1 - 440 pregnant women were referred and received risk assessments by case managers.  2,073 women received prenatal care referrals and information.

<p>3.2 By June 30, 2005, 240 of the women assessed by Pregnancy Connection as a moderate or high-risk pregnancy will receive case management services, as measured by Perinatal Case Management Referral Log and client charts.</p>	<p>3.2 - 311 women were received case management services.</p>
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## **I. Mohave County**

Mohave County is a rural county in the northwestern area of the state and borders the Colorado River. The Mohave County population has grown from 156,032 residents to 180,210 residents over the past year.

The County Board of Health continues to function as the Advisory Council making it possible for input and participation from all areas of the county. They meet quarterly and consist of the community as well as the provider population and are all committed to the same goals and mission of the CPBG program.

The CPBG Coordinator oversees the Health Start Program, CPBG Program, Immunizations, and Community Health Grant. This allows her to maximize services in an economically efficient manner.

- 1. Prenatal Program:** Women who present at the Mohave County Health Department (Mohave CHD) for pregnancy tests and test negative receive information and education on family planning services, preconceptional health, risk behaviors, nutrition counseling, referrals to community resources and folic acid information.

Women who have a positive pregnancy test receive a risk assessment testing, referrals to AHCCCS, WIC, nutrition counseling, prenatal care options and information on the importance of prenatal vitamins. In addition, the CPBG Coordinator has attended Childbirth Education Classes and has become a certified instructor. The CPBG coordinator is a copartner with the Kingman Regional Medical Center to provide prenatal classes and childbirth education classes. They include nutrition, preterm labor, fetal development, postpartum depression, and car seat safety. The hospital has a certified lactation counselor that provides education on breastfeeding in conjunction with the prenatal classes. Women receive referrals to the classes by the hospital, private doctors and the MCHD. A baby shower is provided every other month at a doctor's office. Small groups of pregnant women meet to learn about labor and delivery, postpartum depression and breastfeeding. The CPBG Coordinator has also developed incentives for women to attend the classes. The CPBG Coordinator, along with Kingman Regional Medical Center (KRMC), provides seven (7) postpartum classes to new mothers. They include nutrition, infant massage, infant CPR, and immunizations, back in shape, home safety and car seat safety. New mothers receive a \$25 gift certificate from KRMC to a local restaurant after completing four (4) of seven (7) classes.

High-risk pregnant women and families are also receiving home visits for safety checks, nutrition and preventative health care. The Lay Health Workers also provide these home visits for women who are not qualified to receive Health Start services.

## MOHAVE COUNTY PROGRAM EVALUATION

### Goal 1: Decrease neural tube defects for newborns in Mohave County

Objectives:	Evaluation:
1.1 By December 31, 2005, 140 women will receive education on importance of folic acid and its impact on birth outcome, as measured by pre/posttest.	1.1 - 131 women were educated and received folic acid.  For the first two quarters of 2004-2005, CPBG funds were used to supplement this program.
1.2 By December 31, 2005, women who received folic acid education will demonstrate an 85% increase in knowledge regarding the impact of folic acid on birth outcome, as measured by pre/posttest results.	1.2 - Average pretest score: 12.5%  Average posttest score: 97.5%  97% (performance index) increase in knowledge.

### Goal 2: Improve Birth Outcomes in Mohave County

Objectives:	Evaluation:
2.1 By June 30, 2005, 300 women testing positive for pregnancy will receive a risk assessment and appropriate referrals, as measured by check-off sheets.	2.1 - 1,246 pregnancy tests given.  481 positive pregnancy tests.  380 received a risk assessment.
2.2 By June 30, 2005, 400 women with a negative pregnancy test will receive education on family planning services, preconceptual health, risk behaviors, nutrition and referrals, as measured by check-off sheets.	2.2 - 1,246 pregnancy tests given.  765 negative tests.  485 check-off sheets completed.
2.3 By June 30, 2005, 300 home visits to pregnant women regarding home safety, prenatal care, parenting, etc., as measured by encounter forms.	2.3 - 164 encounter forms were completed.

## J. Navajo County

Navajo County is a rural area located in the northeastern region of the state. Navajo County has grown from 97,470 residents to 107,420 residents over the past year.

The Navajo County Public Health Services District (NCPHSD) has had a lack of consistency with the CPBG Coordinator position. The current Coordinator has been in this position for only one month and is orienting herself to the CPBG program and requirements. She is also the coordinator for the Community Health Grant and realizes how they can work effectively together. She is very familiar with the community and has access to many community contacts. Because of her experience with the Tobacco Education and Prevention Program, she has been able to establish good relationships within the schools in Navajo County and plans on utilizing these relationships to further the goals of the CPBG program. She also expressed her commitment to this program and the need for consistency and staff longevity.

1. **Prenatal Education and Breastfeeding Program:** The Healthy Steps Program was purchased to provide teen-based prenatal education to pregnant teens in local high schools in Navajo County. The program consists of facilitator teaching and the utilization of videos and discussion. Topics include prenatal care, nutrition, infant safety, smoking and substance abuse, exercise, rest, physical changes, emotional changes, and staying in school. The CPBG Coordinator plans to continue to provide this program in Snowflake and Holbrook as well as expand it to other areas of the community. She also plans to offer it at the local health departments and it will be available to the public. She has also developed a letter of introduction for private physicians to inform them of the services offered by the CPBG program, and a checklist of interests and needs for clients that can be used as a referral form.

The CPBG Coordinator has had extensive experience in the Navajo County communities and is utilizing this experience to further the goals of the prenatal program. She is collaborating and networking with other local agencies such as WIC, Healthy Families, local Head Start and daycare programs, Early Head Start, social services and healthcare agencies and private physicians.

Another component to the CPBG will be CPR classes for new moms and will be provided as a module of training in the prenatal classes. The CPBG Coordinator is also planning to provide this service to other social service agencies in the community to assist them in better serving their clients.

2. **Immunizations:** The NCPHSD has always made childhood/infant immunizations a major priority. Although the new CPBG Coordinator is not a nurse and cannot participate in the immunization program, her primary focus on the CPBG will free up nursing time to focus on the infant immunization clinics. Consequently, her efforts indirectly contribute to the completion of this goal.

## NAVAJO COUNTY PROGRAM EVALUATION

### Goal 1: Reduce the number of children with childhood diseases in Navajo County

Objectives:	Evaluation:
1.1 By June 30, 2005, the number of children who will meet the 4:3:1 immunization criteria within the first 24 months of age will increase from 16 to 20, as measured by the spring and fall assessment of immunization coverage level report.	1.1 - 51 children completed the 4:3:1 series before 24 months of age. 1,687 children were immunized.
1.2 By June 30, 2005, 1600 reminder/recall cards will be mailed to children who need to complete vaccinations, as measured by client immunization records.	1.2 - 883 clients were contacted regarding immunizations.

### Goal 2: Decrease the number of low birthweight babies born in Navajo County

Objective:	Evaluation:
2.1 By June 30, 2005, the number of low birthweight babies will decrease from 68 to 56 per year, as measured by hospital statistic records.	2.1 - Total births: 1,009 54 infants were born weighing less than 5.5 pounds.

### Goal 3: Educate women on the importance of prenatal care

Objective:	Evaluation:
3.1 By June 30, 2005, 20 teen mothers will have a better understanding of prenatal care, labor and delivery and postpartum care as evidenced by a 100% in posttest scores.	3.1 - 18 of 20 expected clients completed prenatal courses with an evident increase in knowledge that was measured by an increase in post scores of 100%.

<b>Goal 4: Increase community awareness of passenger safety/injury prevention</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
4.1 By November 30, 2004, three staff will be certified as a Child Passenger Safety Technician, as measured by Safety Technician Certificates.	4.1 - Three staff members were certified as Child Passenger Safety Technicians.
4.2 By December 31, 2004, 72 parents/caregivers will demonstrate proper installation and use of their child restraint systems in their vehicles, as measured by pre/posttest scores and proper installation during hands-on instruction.	4.2 - 68 individuals demonstrated how to properly install child passenger restraint systems.

## K. Pima County

Pima County is an urban county located in southern Arizona that has grown from a population of 843,746 residents to 931,210 residents over the past year. The Pima County Health Department (Pima CHD) has chosen to subcontract with two outside providers to fulfill some of the requirements of this grant. Subcontractors participated in Logic Model training in order to plan and evaluate their program in compliance with the CPBG reporting format. Both agencies were pleased with the outcome and data they are now able to produce. Contractors' reports to PCHD have also significantly improved.

1. **Birth and Women's Health Center (BWHC):** The BWHC has collaborated with the St. Elizabeth's of the Hungry Clinic to provide group prenatal care. Groups are taught with Spanish-speaking providers: a nurse-midwife, and a Community Health Advisor. Collaborative agreements have been made with local providers to serve underinsured women. The prenatal care groups cover topics such as nutrition, anatomy, relaxation, common discomforts of pregnancy, prenatal testing and lab work, sonograms, and managing labor and birth.

Reports from BWHC include extensive demographics, prenatal visits, birth outcomes, etc. Their major goal is to determine if their interventions have a positive impact on birth outcome compared to the general population. This is an excellent means of measuring program impact and effectiveness.

2. **Teen Outreach Pregnancy Services (TOPS):** TOPS provides intensive case management to pregnant teens in Pima County. The program helps pregnant teens overcome barriers they face as well as optimize the outcome for mother and infant. They provide teens with education on prenatal care, childbirth and parenting. They also provide postpartum services and support care, including family planning options. Providers and local agencies refer teens to TOPS as early into the pregnancy as possible. Consequently, teens involved in this program tend to receive prenatal care and education early into the pregnancy (first trimester) and have a very positive birth outcome. The majority of infants born to date have been full term and weighed at least 5.5 pounds.
3. **Additional Programs:** The Prenatal Block Grant program continues to work at establishing and maintaining formal and informal relationships with organizations and agencies providing, facilitating or advocating for health services to women and children. The CPBG coordinator participates in meetings and projects with organizations such as the Pascua Yaqui Community Infant Health Action Team, the Coalition for African American Health and Wellness and the United Way.

The CPBG Program also funded a Pima County Public Health Nurse to do conferences on the "Risky Crib." This is a program that educates parents, as well as professionals, on the hazardous and dangerous items that are frequently left in the baby's crib. The program intends to address SIDS that is becoming all too

common. This program has become popular on a national level as several out-of-state requests for presentations have been made.

The CPBG Coordinator also provides presentations to the Kiwanis Young Children's Council. This organization has provided support to the CPBG Program through assisting with the needs assessment and funding a breastfeeding education program.

## PIMA COUNTY PROGRAM EVALUATION

### **Goal 1: Increase successful pregnancy outcomes by reducing the health disparities among women**

<b>Objectives:</b>	<b>Evaluation:</b>
1.1 By June 30, 2005, a minimum of 100 maternal/child health professionals and/or community members will attend presentations of Perinatal Periods of Risk (PPOR) or MCH data, as measured by sign-in sheets.	1.1 - 500 professional and community members attended PPOR and MCH data presentations.
1.2 By June 30, 2005, 50 community members/health professionals will attend healthy MCH presentations, as measured by presentation evaluations.	1.2 - 265 community members attended Risky Crib presentations.
1.3 By June 30, 2005, participants in the healthy MCH presentations will demonstrate a 20% (performance index) increase in knowledge, as measured by pre/posttests.	1.3 - Participants in healthy MCH presentations (Risky Crib) demonstrated a 53% (performance index) increase in knowledge regarding safe practices.

### **Goal 2: Improve access to prenatal care, resulting in positive and/or improved birth outcomes for women at risk for receiving inadequate prenatal care**

<b>Objectives:</b>	<b>Evaluation:</b>
2.1 By June 30, 2005, 150 pregnant women will receive services from the Birth and Women's Health Center's (BWHC) Centering Group, as measured by quarterly reports.	2.1 - 105 women attended group prenatal care classes.

2.2	By June 30, 2005, at least 33% of BWHC Centering participants will come from target zip codes defined by the PCHD Epidemiology Department as having high levels of women at risk of not receiving adequate prenatal care or of having low birthweight babies, as measured by client files.	2.2 - 19 out of 30 (63%) of women who lived in high-risk areas enrolled in the BWHC program.
2.3	By June 30, 2005, 150 pregnant women will attend 8 or more prenatal visits, as measured by attendance records.	2.3 - 25 of 27 women who delivered (93%) attended a minimum of 8 prenatal visits.
2.4	By June 30, 2005, participants will rate the program an average satisfaction rate of 8 on a scale of 1 to 10, as measured by evaluation sheets.	2.4 - Average evaluation score was 9.2 with 78 out of 105 completing the evaluation.
2.5	By June 30, 2005, 75 participants will demonstrate a 50% increase in knowledge related to prenatal issues, as measured by pre/posttest scores.	2.5 - Pre/posttests were not administered during the first five months of the program. They are now being consistently used, but posttests are not given until after the baby has been born. Comparative data is not yet available.
2.6	By June 30, 2005, 90% of participants who deliver will birth at 37+ weeks gestation, as measured by birth and client records.	2.6 - Out of 27 births, 26 (97%) had an average gestation of 39.5 weeks. No babies were born before 32 weeks.
2.7	By June 30, 2005, 90% of the participants who deliver will give birth to babies who weigh above 5.5 pounds, as measured by birth and client records.	2.7 - Out of 27 births, 26 (97%) had an average birthweight of 7.24 pounds.
2.8	By June 30, 2005, 100 pregnant and postpartum women and their families will receive prenatal, postpartum and infant care education and materials from Public Health Nurses during home visits, as measured by encounter forms.	2.8 - 90 pregnant and postpartum women have received education and materials.

<b>Goal 3: Improve birth outcomes for pregnant teens</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
3.1 By June 30, 2005, 100 pregnant teens will be referred to receive prenatal care in the first trimester, as measured by program referral forms.	3.1 - 101 pregnant teens were referred to the Teen Outreach Pregnancy Services (TOPS).
3.2 By June 30, 2005, 90 pregnant teens will enroll for pregnancy classes in the first trimester, as measured by enrollment data.	3.2 - Of the 101 referrals received, 45 were made in the first trimester.
3.3 By June 30, 2005, 90 enrolled pregnant teens will receive case management services, as measured by completed case management documentation.	3.3 - 88 pregnant teens have received case management services and 8 teens are on a waiting list.
3.4 By June 30, 2005, 90 pregnant teens will attend 6 out of 7 educational classes, as measured by attendance records.	3.4 - 73 teens have completed at least 6 out of 7 classes (55 teens have been 100% compliant) and 8 teens are scheduled to begin classes in July.
3.5 By June 30, 2005, 100 pregnant teens will demonstrate 25% increase in knowledge related to nutrition, preterm labor signs/symptoms, problems in pregnancy, dealing with discomforts importance of hydration, exercise and sexually transmitted diseases, as measured by pre/posttests.	3.5 - Pre/posttests demonstrated a 27% increase in knowledge.
3.6 By June 30, 2005, 100% of delivered teens will have attended at least 8 prenatal care appointments, as measured by participants' surveys.	3.6 - Of the 39 deliveries that occurred by June 30, 38 teens (98%) attended 8 or more prenatal visits. One delivery was preterm to twins at 33 weeks and 7 visits were recorded.

<p>3.7 By June 30, 2005, teens enrolled in TOPS that deliver will have a gestational age of 37 weeks or better, as measured by delivery records.</p>	<p>3.7 - Of the 39 teens that delivered, 37 deliveries were at a gestational age greater than 37 weeks. Two sets of twins delivered at 33 and 34 weeks.</p>
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## **L. Pinal County**

Pinal is a rural county located between the metropolitan counties of Maricopa and Pima. Pinal County has grown from a population of 179,727 residents to 218,285 residents over the past year.

Pinal County's reorganization, dividing the county into three districts, has proven to be the most effective way to deal with the needs of rural communities. Because Pinal County covers such a large geographic area, the three-district system allows for the provision of much needed services to the less populated areas. The CPBG Coordinator continues to coordinate this program and oversee three districts that provide nurse case management services for pregnant women.

1. **Pinal County Maternal Child Health (MCH) Program Integration:** The Pinal County MCH Programs consist of the County Prenatal Block Grant, WIC Program, Immunization Program, AZEIP, Child Safety, Healthy Families, and Health Start Programs.
2. **Nurse Home Visitation Program (NHVP):** The NHVP has become a very successful means to provide prenatal services for clients who live in a rural county and have difficulty accessing services. The main priority is to provide prenatal services for pregnant women who are defined as being at risk. "At risk" is defined as pregnant teens, women with asthma, diabetes, drug history, or history of preterm delivery. With this program, early prenatal care and education is offered. The NHVP is provided early into and throughout the pregnancy. Prenatal education is provided in the home or in their "natural environments" on a one-on-one basis. Initially, every client has an individualized Family Service Plan developed by their Case Manager that is based on their own needs, strengths, and concerns. Monthly pregnancy clinics are held throughout the county. Pregnancy tests are provided and if tested positive, women are enrolled in the program. For women who test negative, information on family planning services is also provided. The CPBG Program also works closely with Health Start, coordinating services and ensuring that all identified and qualified pregnant women in the county will receive prenatal care. For those women who are considered to be at risk, the goal is to provide one home visit per month.

Postnatal visits are also provided by the CPBG Nurse Case Managers as a means of identifying potentially at-risk infants. Follow-up home visits can be provided until the infant reaches the age of two years. Because nurses also work in several of the other MCH programs they have an increased knowledge base and can assist in streamlining services for clients. Because of this program, more women are entering into prenatal care earlier and are demonstrating increased awareness of lifestyle choices and the impact they have on birth outcome. NHVP has become a very effective program that has had a significant positive impact on women and children in Pinal County.

## PINAL COUNTY PROGRAM EVALUATION

### Goal 1: Increase the number of healthy birth outcomes for women of childbearing age in Pinal County

Objectives:	Evaluation:
1.1 By June 30, 2005, 180 home visits to pregnant women in Pinal County will be provided by Public Health Nurses (PHN), as measured by client logs.	1.1 - 221 home visits were made (78 pregnant women).
1.2 By June 30, 2005, 85% of referrals received by PHNs will be contacted within 2 weeks of receipt of referral, as measured by client charts.	1.2 - 70 (90%) of the 78 referrals were contacted within 2 weeks of receipt of referral.
1.3 By June 30, 2005, 85% of new referrals will begin OB prenatal care within 6 weeks of enrollment, as measured by client charts.	1.3 - 70 (89%) began prenatal care within 6 weeks of enrollment.
1.4 By June 30, 2004, 80% of high-risk pregnant women enrolled in the program will receive home case management services and monthly home visits, as measured by client charts.	1.4 - 59 (78%) received monthly home visits.
1.5 By June 30, 2005, 85% of smoking clients will receive the smoking cessation packet, as measured by client surveys.	1.5 - This project started during the 3rd Quarter. To date, surveys did not reflect a need for smoking cessation referrals.
1.6 By June 30, 2005, clients will increase their knowledge of prenatal health by 20%, as measured by pre/posttest scores.	1.6 - Insufficient data to determine percent of increase: 15 pretests and only 4 posttests were completed.

<p>1.7 By June 30, 2005, 100% of prenatal clients will receive breastfeeding information by their third trimester, as measured by chart audits.</p>	<p>1.7 - 27 women received breastfeeding information by the 3rd trimester.</p> <p>NOTE: Achieving the objective cannot be measured as the actual number of women who were in their 3rd trimester is missing.</p>
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## M. Santa Cruz County

Santa Cruz is a rural county bordered by Mexico to the south and Pinal County to the north. Santa Cruz County has grown from a population of 38,381 residents to 41,985 residents over the past year.

The County Prenatal Block Grant has been subcontracted to Mariposa Community Health Center (MCHC) since October 2003. MCHC is a cultural Center of Excellence in women's health issues. MCHC has traditionally provided services that focus on women's health and maternal child health issues. MCHC is a National Center of Excellence in Women's Health. The programs that the MCHC staff provides have been the main source of services and support for women in the county and the CPBG program provides them with some additional funding needed to expand what has traditionally been an exceptional program. The MCHC has also hired a Nurse Practitioner to provide prenatal case management services and consultation to promotoras for high-risk pregnant women and women who do not qualify for Health Start. In addition, the CPBG Coordinator is currently involved in the Rocky Mountain Maternal and Child Health Certificate program.

1. **Mariposa Community Center of Excellence (MCCOE):** The MCCOE began in 2002 and was established to improve the health and social well being of women through a participatory, community-based systems approach that provides the framework for improving comprehensive service delivery, health promotion, training and leadership development targeted at reducing health disparities and increasing access to care.

The Lay Health Workers/Promotoras conduct the classes, provide outreach efforts to involve women, assist women in scheduling routine health maintenance visits, and provide women with a Women's Health passport and Women's Resource Directory. They also provide monthly health education classes on nutrition, physical activities reproductive health and, when needed, arrange transportation to classes.

MCHC also participates in an Obesity Prevention Program that involves student interns, including social work and nursing students. They provide home visits with promotoras or coordinators and provide counseling and education related to nutrition, life choices and self-esteem issues for pregnant women. Five interns per semester are available which limits the number of women that can be seen. The program has become so effective that there is a waiting list.

2. **Folic Acid Program:** Since October 2002, MCHC has been the primary provider of Folic Acid education and supplements. They have traditionally had a very good working relationship with WIC and, through the requirements of the CPBG contract, have developed a very successful and popular Folic Acid program in Santa Cruz.

3. **Breastfeeding Program:** Breastfeeding has traditionally been a major concern for MCHC. The Prenatal Program staff have taken breastfeeding into the community by providing training to MCHC staff as well as the local hospital. Lactation Counseling training is scheduled for the hospital staff this year. In previous years, the CPBG program funded the training of Certified Lactation Counselors (CLCs), who were employed by MCHC. In addition, a part-time WIC worker, trained with CPBG dollars, also functions as a part-time CLC for MCHC. Everyday a Lay Health Worker/CLC is available at the local hospital to instruct new mothers on the benefits of breastfeeding. Education, follow up, and support are also provided in the home to encourage women to continue breastfeeding.
4. **Car Seat Safety:** MCHC has begun to focus on developing a car seat safety program by providing a Car Seat Rodeo. Lay Health Workers conducted in-home car seat education and inspections. Arrangements have been made to acquire car seats from the Governor's Office of Highway Safety in order that they may be provided to low-income families.

## SANTA CRUZ COUNTY PROGRAM EVALUATION

### **Goal 1: Improve the overall health status of women of childbearing age, pregnant and lactating women, newborns, infants and children in Santa Cruz County**

#### **Objectives:**

#### **Evaluation:**

1.1 By June 30, 2005, 140 women will receive breastfeeding education and/or lactation counseling, as measured by hospital logs.

1.1 - 66 women received education and/or counseling.

1.2 By June 30, 200, 50 families will receive car seat inspections and/or instructions, as measured by staff documentation.

1.2 - 62 in-home car seat instructions, classes, inspections and installations were conducted.

### **Goal 2: Improve birth outcomes for women**

#### **Objectives:**

#### **Evaluation:**

2.1 By June 30, 2005, 100 women will receive prenatal services, as measured by staff logs.

2.1 - 522 women: prenatal care, prenatal classes, gestational diabetes classes, labor and delivery.

2.2 By June 30, 2005, 25% of prenatal high-risk pregnant women will receive case management services, as measured by client logs.

2.2 - 99 prenatal high-risk clients.

2.3 By June 30, 2005, 80 women will receive folic acid education and supplements, as measured by client participation forms.

2.3 - 112 women received folic acid education and supplements.

Although this program is funded by ADHS, there is no adequate funding for the educational component or coordination of the program. Consequently, CPBG funds were used to supplement this program.

## N. Yavapai County

Yavapai County is a rural county, located in the midwestern area of the state and covers 65,000 square miles and has three Indian Reservations. The county has grown from 167,517 residents to 196,720 residents in the past year.

The Yavapai County Community Health Services' (YCCHS) Maternal and Child Health (MCH) program consists of seven public health nurses, four community health workers, a masters level counselor and a senior secretary. The education, experience and quality of the MCH staff are exceptionally notable. Nurses have been trained in a very wide range of public health issues to address the diverse needs of the women and children in Yavapai County. They have received thorough training in the following areas: prenatal risk assessments, car seat safety, developmental assessments, oral health, tobacco cessation, mental health/postpartum depression, high-risk perinatal services, and child health and safety issues. Their approach to public health nursing addresses those they serve in a holistic manner that is more accurately described as Public Health Nursing with a social work approach. In addition, two of the public health nurses and all of the community health workers are bilingual.

- 1. Prenatal Care Services:** The Public Health Nurse (PHN) home visiting program has become a priority program for MCH services. To improve accessibility and continuity of care, the CPBG Coordinator also functions as the WIC supervisor. Beginning in June 2004, the PHNs began making home visits to pregnant and postpartum women to conduct a comprehensive risk assessment which covers medical, obstetric, mental health, social and parenting issues. The initial assessment in the prenatal period is to provide information to address preterm labor and birth. The focus in the postpartum period is on mental health (specifically depression), social and parenting issues. Upon completion of the assessment, it is scored and a family-focused plan is developed based on the concerns of the client and level of risk. The level of risk determines if the PHN will continue to see the client or if she should be referred to the Health Start Program. If warranted, the PHN continues to provide consultation to Health Start staff in following up with at-risk pregnant women and teens. Providers are oriented to the home visiting program and referrals are also received through the YCCHS Pregnancy Testing Program.

YCCHS has also developed a prenatal class for Spanish-speaking women. It was identified in their needs assessment that the hospital provides prenatal classes for English-speaking women but there is a significant language barrier for both the women and the hospital staff for the Spanish-speaking population. Prenatal classes began in the fourth quarter, but funding and staffing issues have prevented the program from expanding as they had planned. However, they have addressed these issues and will expand as planned for the upcoming year.

## **2. Prevention Programs:**

- The Preconceptual Health Program includes education and training to women of childbearing age on the importance of healthy lifestyles prior to pregnancy. It includes information on the effects of proper nutrition, smoking cessation, harmful effects of drugs and alcohol and the use of folic acid on birth outcome—primarily for women who are not pregnant.
- Infant Health and Safety: Public Health Nurses provide home visits to new mothers to provide developmental assessments, home safety inspections, car seat safety, oral health education, identification and intervention for high-risk infants and identification and intervention for maternal depression. A postpartum depression assessment has also been developed to early identify women who are at risk.

Currently there is no funding that can be used to supplement these programs. Although the program is very successful and comprehensive, the numbers of clients and extent of service provision is significantly limited due to lack of funding. Yavapai County continues to pursue additional funding to expand and improve the current program as well as address future needs in the communities.

## YAVAPAI COUNTY PROGRAM EVALUATION

### Goal 1: Increase knowledge and awareness of healthy behaviors in pregnant women

Objectives:	Evaluation:
1.1 By June 30, 2005, 100 pregnant women will attend prenatal and childbirth classes, as measured by class sign-in sheets.	1.1 - 203 women were educated (45 of which were Spanish speaking only).
1.2 By June 30, 2005, 100 pregnant women will develop a plan to set a minimum of 3 goals for improving their health and that of their children, as measured by chart documentation.	1.2 - 203 women set goals and developed plans to improve health of themselves and their families.

### Goal 2: Improve birth outcome for women in Yavapai County

Objectives:	Evaluation:
2.1 By June 30, 2005, 100 pregnant women will have received a comprehensive prenatal risk assessment by a Public Health Nurse, as measured by the client's chart.	2.1 - 202 women received a prenatal risk assessment.
2.2 By June 30, 2005, 100 women will have received information on signs and symptoms and causes of preterm labor, as measured by documentation in client chart.	2.2 - 214 women received information from Community Health Nurses during home visits.

### Goal 3: Increase pregnant women's ability to improve their nutritional status

Objectives:	Evaluation:
3.1 By June 30, 2005, 20 pregnant clients will be referred to WIC for nutrition education and food vouchers to supplement their food resources, as measured by documentation in client charts.	3.1 - 78 women were referred to WIC.

3.2 By June 30, 2005, 30 pregnant women will receive prenatal vitamins, as measured by prenatal vitamin log and client chart.	3.2 - 178 pregnant women were provided with prenatal vitamins.
<b>Goal 4: Increase access to mental health services for women who are pregnant and/or postpartum</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
4.1 By June 30, 2005, 30 client cases will have received consultations by the MCH counselor to Public Health Nurses and Community Health Workers, as measured by staff monthly report.	4.1 - 126 case consultations with MCH counselors were provided.
4.2 By June 30, 2005, 10 MCH clients will have acquired mental health services in a clinical setting with the assistance of MCH staff, as measured by counselor's monthly report.	4.2 - 19 women received mental health clinical services.
4.3 By June 30, 2005, 50 postpartum women will be assessed for postpartum depression by a Public Health Nurse, as measured by documentation in clients' charts.	4.3 - 98 postpartum women were assessed for depression.

## O. Yuma County

Yuma County is an urban border county that is located in the Southwestern part of the state. It has grown from 160,026 residents to 181,470 residents in the past year.

1. **Community Involvement:** Community involvement and outreach continues to be an important component of the Yuma County Health Department (YCHD) CPBG program. The CPBG Coordinator participates in the Yuma County Child Abuse Prevention Council, the Marine Corps Air Station Coalition and the Family Youth Connection. In addition, the CPBG Coordinator has provided a number of community presentations related to maternal child health, prenatal care, and teen pregnancy and parenting programs.
2. **Yuma County Maternal Child Health (MCH) Advisory Council:**  
The Yuma County Advisory Council is quite active. They have formed two subcommittees that work closely together on major community projects related to maternal and child health issues. Nurturing Families Subcommittee (previously Peer Teaching and Nurturing Subcommittees) and the Opportunities Subcommittee (previously the Awareness and Opportunity Subcommittees) each met on a monthly basis.
3. **Teen Education and Prenatal Programs:**
  - **Prenatal Teaching and Case Management Programs:**  
The CPBG Coordinator is available to provide services to all women of childbearing age. However, because Yuma County ranks first in the state for teen pregnancies, according to the ADHS Bureau of Health Statistics, the CPBG Coordinator and the YCHD focus a great deal of their efforts on this population. An extensive outreach, teaching and case management component has been developed. The majority of teens being case managed are between the 15 and 17 years of age. The major objectives of this program focus on early prenatal care, breastfeeding education and car seat safety.
  - **Teen Maze:**  
With the combined efforts of the CPBG Coordinator and the Yuma County MCH Advisory Council, the annual Teen Festival was held. Again it was an enormous success. This annual event has become very popular in Yuma County. This year, in addition to the regularly scheduled festival, a multinational event was held in San Luis, Arizona and San Luis, Mexico. The events were held on the same day. It was the first time such an endeavor has been attempted and the results were an astounding success.

In addition, the east county area has been traditionally hard to reach. The CPBG program held a Teen Maze for the first time in Welton and is considered to be so much of a success that they were asked to return at the parents' request.

<b>YUMA COUNTY PROGRAM EVALUATION</b>	
<b>Goal 1: Increase the number of positive birth outcomes in Yuma County</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
1.1 By June 30, 2004, 30% of teens in the Prenatal Teaching Case Management Program will access medical care in the first trimester of their pregnancy (more than 5 medical visits), as measured by case management reports.	1.1 - 27 (36%) of the teens began prenatal care in the first trimester. 24 (32%) had more than 5 visits.
1.2 By June 30, 2005, 30% of the teens being enrolled for case management follow up will be in the first trimester of pregnancy as evidenced by enrollment forms.	1.2 - 50 teens (35%) were enrolled in case management in the first trimester.
1.3 By June 30, 2005, 12 community presentations will be provided regarding teen pregnancy and/or teen preconceptual health care issues, as measured by the Activity Logs.	1.3 - Total presentation for the year: 37
<b>Goal 2: Increase the number of new mothers who choose to breastfeed</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
2.1 By June 30, 2005, 100 of the teens enrolled in case management program will receive information and education on breastfeeding, as measured by case management reports.	2.1 - 103 pregnant teens received education on breastfeeding.
2.2 By June 30, 2005, 50 women will be provided a breastfeeding event or presentation, as measured by evaluation sheets.	2.2 - The event is in the planning stages. No data available.

<b>Goal 3: Reduce the number of infant mortalities due to motor vehicle accidents</b>	
<b>Objective:</b>	<b>Evaluation:</b>
3.1 By June 30, 2005, 143 teens currently under case management services will be able to obtain free car seats after completing the program and received car seat classes, as measured by completed vouchers.	3.1 - 21 teens have received vouchers.  This program will take time to implement and document as the car seats will be given late in the pregnancies.
<b>Goal 4: Increase the knowledge base on Maternal Child Health issues of teens and parents of teens</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
4.1 By June 30, 2005, two seminars or teen festivals will be held to provide information on services, pregnancy, HIV, sexually transmitted diseases, abstinence, parenting and careers, as measured by evaluation sheets.	4.1 - 2 Teen Mazes were held.
4.2 By June 30, 2005, 550 teens will attend Teen Mazes, as measured by evaluations.	4.2 - 775 teens participated in Teen Mazes.

## VI. STATEWIDE AGGREGATE EVALUATION SUMMARY

The matrix below reports the total numbers of services and individuals served throughout the state. Each Goal reported has an objective(s) that is relatively generic to all or most of the counties. The last column in the matrix contains the evaluation of the objective(s). It is well to note that the “Additional Programs” and numbers of individuals they served are not included in the aggregate amounts. In addition, some of the numbers reported are in bold. This indicates they are unduplicated amounts and, if totaled will equal a relatively conservative amount of 20,146 women, children, expecting fathers and community members.

Goal 1 Objective 1 defines the target population (women of childbearing age, teens, and expecting fathers), includes the list of services received, and how they were measured. Results of the evaluations show that the CPBG Program, statewide, has provided **14,288** women, teens and expecting fathers with prenatal or perinatal services. This number is a compilation of people who received the services that are listed below the aggregate number of 14,288.

Not included in the 14,288 individuals is Goal 1 Objective 10 that reports **2,693** families that received information on community resources. This number was not included in Objective 1 because they were not individuals and they received information rather than actual services. However, they are included in the overall number of 20,146 as reported in the CPBG Statewide Aggregate Evaluation.

Goal 2 reports that **126** women received mental health consultations. Of the 126 women, 98 were assessed for depression and 19 women actually received clinic services.

Goal 3 Objective 1 reports **2,471** infants and children under the age of two years received services. Of the 2,471 infants and children receiving services, 1,687 were assessed for appropriate immunizations. In order to guard against duplication, the 784 pregnant women and children that received safety and lead exposure checks included the 436 children receiving child safety restraints.

Goal 4 reports the efforts counties have made towards developing a coordinated system of care. There were **568** professionals, community organizations and agency representatives that participated in, collaborated with and/or committed to activities that would improve the health care delivery system.

The results of the current planning, implementation, evaluation and reporting process used by the CPBG Program demonstrated that a total of 20,146 Arizona residents were impacted by this program. The actual breakdown in services and numbers are listed in the Statewide Aggregate Evaluation below.

## VII. CPBG STATEWIDE AGGREGATE EVALUATION 2004-2005

<b>Goal 1: Improve birth outcomes for infants born in the state of Arizona</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
1.1 By June 30, 2004, <b>7,250</b> women of childbearing age, teens, expecting fathers, infants and children will receive at least one of the following: prenatal classes, prenatal care in the first trimester, pregnancy tests, information and referral, risk assessments, case management services, home visits, and education on birth outcome, breastfeeding, parenting and bonding, family planning and preconceptual health, as measured by class sign-in sheets, encounter forms and/or test results.	1.1 - <b>14,288</b> women, teens, infants and expecting fathers received one or more of these services.  (Unduplicated)  <b>Actual services are broken down below.</b>
1.2 By June 30, 2005, 675 pregnant women will complete at least one of the following prenatal care classes: childbirth, nutrition, labor and delivery education classes, as measured by class sign-in sheets.	1.2 - 1,276 women attended and completed at least one of the classes.  (Numbers included in 1.1)
1.3 By June 30, 2005, those who attend classes will demonstrate a 50% increase in knowledge regarding one or more of the following: prenatal care, nutrition, childbirth, breastfeeding, parenting, etc., as measured by pre/posttest results.	1.3 - There was an average 54% increase in knowledge.
1.4 By June 30, 2005, 260 women and teens who are enrolled in the CPBG Program will enter prenatal care in the first trimester, as measured by client files.	1.4 - 366 women entered into prenatal care in the first trimester in the five (5) counties that reported entry into prenatal care.  (Numbers included in 1.1)

1.5 By June 30, 2005, 90 babies born from mothers who participated in the CPBG Program will weigh more than 5 lbs. 8 oz., as measured by client charts and hospital records.	1.5 - 95 babies born weighed more than 5 lbs. 8 oz. in the three (3) counties that reported birthweight.  (Numbers included in 1.1)
1.6 By June 30, 2005, 1,000 women who test positive for pregnancy will be assessed for needs and will receive referrals and/or information on community resources, and educational materials, as measured by client charts.	1.6 - 3,351 women were tested positive for pregnancy and provided with referrals, information and assessments.  (Numbers included in 1.1)
1.7 By June 30, 2005, 425 pregnant women, considered to be at risk, will receive case management services, as measured by client records.	1.7 - 579 at-risk pregnant women received case management services in the four (4) counties that reported case management services.  (Numbers included in 1.1)
1.8 By June 30, 2005, 1,580 women will receive folic acid supplements and information and education related to neural tube defects, as measured by client logs.	1.8 - 1,824 women were provided with education and folic acid supplements.  (Numbers included in 1.1)
1.9 By June 30, 2005, 1,250 women who have a negative pregnancy test will be referred to family planning services, preconceptual health and other community resources, as measured by client charts.	1.9 - 1,477 women tested negative for pregnancy and were referred to appropriate resources.  (Numbers included in 1.1)
1.10 By June 30, 2005, 870 families will receive information on local health, social services and insurance programs through public events and media opportunities.	1.10 - <b>2,693</b> families were provided information on community resources.

1.11 By June 30, 2005, 300 women will be provided with breastfeeding information and education, as measured by client records.	1.11 - 296 women received breastfeeding education, support and information in the three (3) counties reporting breastfeeding education.  (Numbers included in 1.1)
1.12 By June 30, 2005, 70 expecting fathers will receive infant care and bonding education, as measured by class sign-in sheets.	1.12 - 94 fathers attended childbirth education, infant care and bonding classes in the two (2) counties that reported this service.  (Numbers included in 1.1)
1.13 By June 30, 2005, 1,600 teens will be educated on parenting, puberty, maturation, sexuality, pregnancy, sexually transmitted diseases, preconceptual health, consequences of substance abuse, poor nutrition, and the impact of birth outcome, as measured by sign-in sheets.	1.13 - 2,237 teens attended events and classes that would impact risk-taking behavior.  (Numbers included in 1.1)
<b>Goal 2: Increase access to mental health services for pregnant or postpartum women</b>	
<b>Objective:</b>	<b>Evaluation:</b>
2.1 By June 30, 2005, 30 client cases will receive consultation from the MCH counselor to Public Health Nurses and Community Health Workers, as measured by staff monthly report.	2.1 - <b>126</b> women received mental health consultations.  (Unduplicated)  98 women were assessed for depression.  19 women received clinic services.

<b>Goal 3: Reduce the incidence of childhood diseases, avoidable injuries and infant mortality</b>	
<b>Objectives:</b>	<b>Evaluation:</b>
3.1 By June 30, 2005, 870 infants and children under the age of two years will receive a minimum of one of the following services: immunizations or assessments, car safety restraints and/or education and home safety inspections, as measured by medical logs, sign-in sheets or inspection logs.	3.1 - <b>2,471</b> infants and children received services. (Unduplicated)
3.2 By June 30, 2005, 70 infants/children will have received age-appropriate immunizations, as measured by medical logs.	3.2 - 1,687 infants/children were assessed. 276 were determined to have completed age-appropriate immunizations. (Numbers included in 3.1)
3.3 By June 30, 2005, 600 pregnant women and children will receive lead poisoning screening and home-safety checks, as measured by safety-check log and lead samples.	3.3 - 784 pregnant women and children received home-safety and lead-exposure checks. (Numbers included in 3.1)
3.4 By June 30, 2004, 200 families and caregivers will receive car safety restraints and education on proper installation, as measured by sign-in sheets.	3.4 - 436 car safety restraints, education and installation checks were provided in six (6) counties. (Duplicate numbers - included in 3.3)

<b>Goal 4: Improve the infrastructure of the perinatal services delivery system</b>	
<b>Objective:</b>	<b>Evaluation:</b>
4.1 By June 30, 2005, 165 health social services and community organization and professionals will receive newsletters, and participate in collaborative activities, meetings and training opportunities and commit to participate in coalition activities.	4.1 - <b>568</b> professionals and community organization and agency representatives participated in activities to improve health care delivery system.  (Unduplicated)

## VIII. CONCLUSION

The CPBG works toward developing a system of care that is streamlined, seamless, and accessible to Arizona's women and children. When asked what their county would look like without the CPBG, counties reported that there would be no maternal child health programs, less community involvement and input, less coordinated systems of care, minimal program planning based on local needs and no process to evaluate program effectiveness. They also commented on how the grant has served two major purposes:

- A. The CPBG encourages counties to creatively structure programs that are streamlined; accessible to women and children; and community based. "Community based" means programs are developed with input from the community and includes participation of other agencies serving the same target population. By coordinating efforts and resources, programs and services have improved and counties are empowered to create programs that fit their own needs and characteristics.
- B. All counties are required to develop an action plan that is based on the community needs assessment. Counties evaluate their progress on a quarterly basis. Counties have reported this helps keep them focused and on track.

Counties now collaborate with each other and with other health and social services agencies. They have developed creative financing strategies that combine resources of several programs resulting in getting the biggest bang for the buck. This merging of resources has also resulted in the development of a strong networking component that will ultimately lead to a seamless system of care. Many counties, especially the rural counties, depend on the CPBG to fund all of their Maternal Child Health Programs. The reduction or elimination of their funding would have devastating results on health services for women, infants and children statewide.